# 2025—2026 Health Plan Highlights

| Key Medical Benefits | HPN Copay | HPN HDHP |
|---|---|---|
| | In Network Only | In Network Only |
| **Deductible** (per plan year) | | |
| Individual / Family | $2,500 / $5,000 | $3,300 / $6,600 |
| **Out-of-Pocket Maximum** (per plan year) | | |
| Individual / Family | $8,150 / $16,300 | $7,050/ $14,100 |
| **Covered Services** | | |
| Office Visits Primary Care | $70 copay, $15 clinic | 30% coinsurance*, $15 clinic |
| Virtual Visits | $12 copay, $15 clinic | $42, $15 clinic |
| Specialist Care | $70 copay | 30% coinsurance* |
| Routine Preventive Care | No charge | No charge |
| Outpatient Diagnostic (lab/X-ray) | 30% coinsurance* | 30% coinsurance* |
| Complex Imaging (MRI, CT Scan, Ultrasound) | 30% coinsurance* | 30% coinsurance* |
| Ambulance | 30% coinsurance* | 30% coinsurance* |
| Emergency Room | $500 copay (waived if true emergency) per visit plus deductible, then coinsurance | |
| | Freestanding emergency room $500 copay per visit plus deductible, then coinsurance | |
| Urgent Care Facility | $50 copay | 30% coinsurance* |
| Inpatient Hospital Stay | 30% coinsurance* | 30% coinsurance* |
| Outpatient Surgery | 30% coinsurance* | 30% coinsurance* |
| **Prescription Drugs** | (Generic/ Brand Name/ Non-Preferred Brand Name/ Specialty) Routine Prevention Rx—covered in full | |
| Retail Pharmacy (30-day supply) | $15/ 30%*/ 50%*/ 30%* | 20%*/25%*/50%*/ 20%* |
| Mail Order (90-day supply) | $45/ 30%*/ 50%* | 20%*/ 25%*/ 50%* |

**Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.**

*** Benefits with an asterisk(*) require that the deductible be met before the plan begins to pay.**